

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	1	5	1	2										
												REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
Elizabeth			Wilhemina			Boulter						June 22, 1979						10 08 p.m.								
3. SEX			4 RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS									
Female			White			MONTH May			DAY 22			YEAR 1885			94 YRS.		MONTHS DAYS		HOURS MIN							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH														
Maryland			United States			MARRIED <input type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			Kent County														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Chestertown			Kent & Queen Anne's Hospital									Housewife														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS														
Maryland			Queen Anne's			Centreville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Rt. #2, Box 399														
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME														
			Henry			NMN			Mercer			Lizzie			Heinefield											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT						16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
No			220-52-7989			Hospital Records						Chestertown, MD 21620														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																										
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>																										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																										
(b) <i>Pneumonia</i>																										
DUE TO, OR AS A CONSEQUENCE OF (c)																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE												
22a. I certify that (I) (we) attended the deceased from <i>June 21, 1979</i> to <i>June 22, 1979</i> , that (I) (we) last saw the deceased alive on <i>June 22, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <input checked="" type="checkbox"/> did not <input type="checkbox"/> view the body after death.																										
22b. SIGNATURE <i>K. K. Wun, M.D.</i>												DEGREE														
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kin-Kue Wun, M. D.</i>												22e. DATE SIGNED														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>												23b. DATE <i>6/26/1979</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Wesley Chapel Cem.</i>			23d. LOCATION CITY OR TOWN <i>Rock Hall, Md.</i>			23e. STATE <i>Rock Hall, Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Willie Wells</i>												ADDRESS <i>Chestertown, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>JUN 28 1979</i>			25b. REGISTRAR'S SIGNATURE <i>Linda Brandy</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 9 1 5 1 2 2
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR				
VICTORIA C BUTLER				JUNE 20, 1979				M				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MAY 3, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 yrs.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN		
7a. BIRTHPLACE MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT						
10. CITY OR TOWN OF DEATH Chesterstown				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION KENT-QUEEN ANNE'S HOS.				12a. USUAL OCCUPATION LABOR				
13a. STATE MD				13b. COUNTY KENT		13c. CITY OR TOWN WORTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.		
14. FATHER'S NAME JAMES A				15. MOTHER'S MAIDEN NAME Alice				12b. KIND OF BUSINESS OR INDUSTRY Various				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-14-186				17. INFORMANT MRSS. 320 N. A.B. HALLAN 1394 W. 11TH ST. (W. 11th and 1394)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b), DUE TO, OR AS A CONSEQUENCE OF (c),												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1 1970</u> to <u>Dec 16 1978</u> , that (I) (we) last saw the deceased alive on <u>Dec 1 1978</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>C. Gottfried Baumann</u>				22c. DEGREE M.D.				22d. DATE SIGNED 6/28/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann				22e. ADDRESS Chesterstown, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial				23b. DATE 6-23-79		23c. NAME OF CEMETERY OR CREMATORIAL UNION CEM.		23d. LOCATION CITY OR TOWN WORTON		COUNTY KENT		
24. FUNERAL DIRECTOR NAME Kenneth W. Waller				25a. DATE REC'D. BY REGISTRAR JUL 24 1979				25b. REGISTRAR'S SIGNATURE F. O. Kelly				

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Items 21c. & 22a.

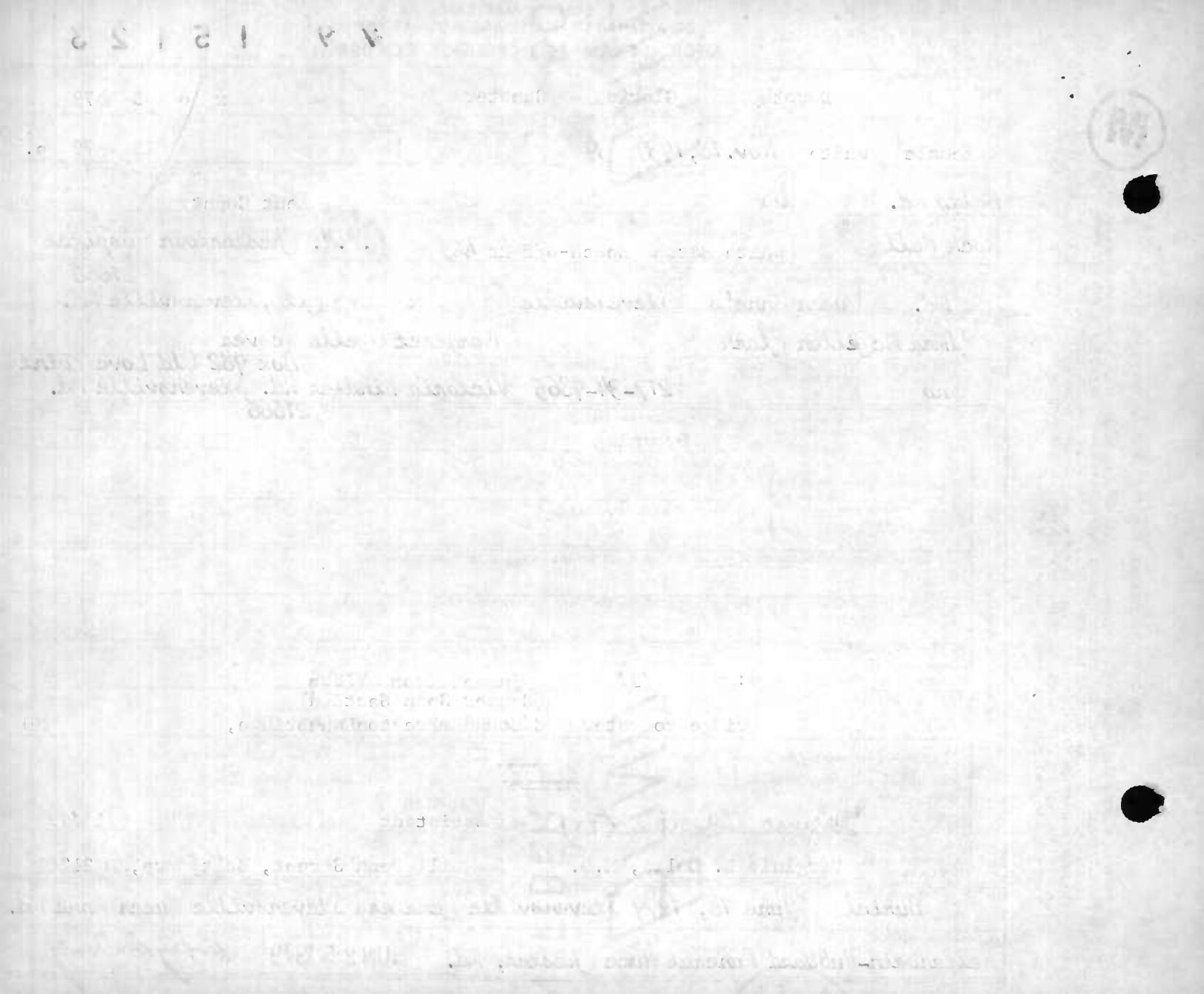
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15123

1. DECEASED NAME (TYPE OR PRINT)		FIRST Dorothy	MIDDLE Gloria	LAST Chester	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH 6	DAY 3	YEAR 1979	2b. HOUR M	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1939	6. AGE (IN YEARS LAST BIRTHDAY) 39 yrs.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 6 15 1979	MONTH 6	DAY 15	YEAR 1979	2d. HOUR 5:30 P.M.
9. BIRTHPLACE (STATE OR HOME COUNTRY) Balto Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County				
10. CITY OR TOWN OF DEATH Rock Hall		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) White Marsh Beach-off Rt 445				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N. (Nestertown Hospital		12b. KIND OF BUSINESS OR INDUSTRY 21666		
13a. STATE Md.		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Bay City, Stevensville Md.		
14. FATHER'S NAME FIRST Elmer McCallan Clark		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Margaret Ozella Weaver		17. INFORMANT Victoria Lindler		16. ADDRESS Box 782 Old Love Point Rd. Stevensville Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-34-9865		17. INFORMANT Victoria Lindler		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 984- IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 4:59 P.M. MONTH DAY YEAR 6/3/1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Precipitated from bridge. jumped from bridge (Center Span Section)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bridge to water		21f. LOCATION STREET E/BoundWmPrestonLaneBridge,		21g. COUNTY STATE MD				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Virginia L. Dolan 79</u> M.D. TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. Assistant MEDICAL EXAMINER										
23a. FURNITURE, CREAMERY, REMOVAL (SPECIFY) Burial		23b. DATE June 18, 1979		23c. NAME OF CEMETERY OR CREMATORIY Stevensville Cemetery		23d. LOCATION CITY OR TOWN Stevensville		23e. COUNTY STATE Queen Anne Md.		
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home		ADDRESS Chester, Md.		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE <u>Virginia L. Dolan</u>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGES 3 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	1	5	1	2	4				
1 - FOR STATE REGISTRAR			REG. NO.																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Joseph			Clement			Craddock			Sr.			June 1, 1979						A 8:16 M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male			White			MONTH DAY YEAR			89			MONTHS	YEARS	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Delaware			U.S.A.									Kent County									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown			Kent and Queen Anne's Hospital, Inc.												Lino-Type Operator			Printing			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Maryland			Kent			Galena			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			P.O. Box 118									
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME									
Theodore Benjamin									Craddock			Frances			NMN Cates						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes			WWI			163-07-2471			Hospital Records - Chestertown, Maryland												
4590									4590												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any									DUE TO, OR AS A CONSEQUENCE OF (b)												
									DUE TO, OR AS A CONSEQUENCE OF (c)												
									Hemorrhage + chronic duodenal disease												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
May 10-1979			rectovag												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
						P.M. 19															
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			STREET			CITY OR TOWN		COUNTY		STATE					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																					
22a. I certify that (I) (this hospital) attended the deceased from May 9, 1979, to June 1, 1979, that (I) (we) lost saw the deceased alive on June 1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death.																22c. DATE SIGNED					
22b. SIGNATURE D. W. Farr																22d. DEGREE					
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																22e. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																22e. ADDRESS					
Robert W. Farr, M.D.																Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION												
Burial			6/7/79			Forrest Cemetery			CITY OR TOWN			COUNTY		STATE							
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Howard E. Fellows, Millington, Md. 21651									JUN 4 1979												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										9	1	5	1	2	5
										REG. NO.					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			John William Hodges Crouch						6-22-79			12:30 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Male			White			May 14, 1905			74 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			U.S.A.						Kent County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Chestertown			Kent and Queen Anne's Hospital			Owner			Marina						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland			Kent			Rock Hall						Rte. #1 Box 166			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
John James Grouch			Mary ? Hodges												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			21620			
No			220-32-0075			Hospital Records - Chestertown, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
410- Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause, if any.										DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest					
										DUE TO, OR AS A CONSEQUENCE OF (c) 4-SCUD					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 22, 1979, to June 22, 1979, that (I) (we) last saw the deceased alive on June 22, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED					
22d. SIGNATURE Wesley										DEGREE M.D.					
22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS									
Patrick A. Molony, M.D.						Chestertown, Maryland 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY STATE			
BURIAL			6-26-79			WESLEY CHAPEL CEM.			ROCK HALL			KENT MD			
24. FUNERAL DIRECTOR NAME			ADDRESS			RT#1 Box 67			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
HELFENBACH-HUBBARD FUNERAL HOME CHESTER									JUN 27 1979			Patrick Molony			

C S I C T Q S

5 12 1251 1 2 6

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. *Given 1 and 2*
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. *Given 1 and 2*
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First LON W. GILLENTWATER	Middle	Lost	20. DATE OF DEATH Month June 8, 1979 Day Year	2b. HOUR 10:30
3. SEX male	4. RACE white	S. DATE OF BIRTH Oct. 3, 1905	6. AGE (In years lost birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Saltville, VA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Betterton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AT Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Sun Oil Machinist	12b. KIND OF BUSINESS OR INDUSTRY Md.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ST Md.	13b. COUNTY Kent	13c. CITY OR TOWN Betterton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME Floyd Gillenwater	First Middle Lost	15. MOTHER'S MAIDEN NAME First Susan White	Middle Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> Navy	16b. SOCIAL SECURITY NO. WW2 163 07 1530	17. INFORMANT Wife	Address Betterton Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 42932					
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) DUE TO, OR AS A CONSEQUENCE OF					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 2-22 , 19 68 , to 6-8 , 19 79 , that (I) (we) last saw the deceased alive on 5-14 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert W. Farr		DEGREE ATTENDING PHYS. MD. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 6/8/79		
22d. PHYSICIAN'S NAME (Type) Robert W. Farr		22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 11, 1979	23c. NAME OF CEMETERY OR CREMATORIAL Still Pond Cem.	23d. LOCATION (City or Town) (County) (State) Still Pond, Md.		
24. FUNERAL DIRECTOR J. Willis Wells	ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR DATE JUN 12 1979	25b. REGISTRAR'S SIGNATURE Hector McCloskey		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 15127

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Miller	MIDDLE David	LAST Goodman	2a. DATE OF DEATH June 16, 1979	MONTH JUNE	DAY 16	YEAR 1979	2b. HOUR 12:10 PM		
3. SEX Male			4. RACE White	5. DATE OF BIRTH MONTH December DAY 25 , YEAR 1892			6. AGE (IN YEARS LAST BIRTHDAY) 86			IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County			
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 2 Box 162		
14. FATHER'S NAME FIRST William			MIDDLE Wilton	LAST Goodman	15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Anna	LAST Pearce	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Army - WW1 217-16-9482			17. INFORMANT ADDRESS Hospital Records Chestertown, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 496 - COPD			DO TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DO TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Tumor of Lung - prob. Ca												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from the deceased alive on June 16, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE C. Gottfried Baumann, M.D.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6/18/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann, M.D.			22e. ADDRESS Chestertown, Maryland 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 18, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cemetery Rock Hall Kent Co. Md.			23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall Kent Co. Md.			
24. FUNERAL DIRECTOR NAME Helpenbein-Hubbard Funeral Home Chester, Md.			25a. DATE REC'D. BY REGISTRAR JUN 22 1979			25b. REGISTRAR'S SIGNATURE Helpenbein-Hubbard						
BP												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	1	5	1	2	8
												REG. NO.					
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
	Lillie Viola Hadaway						June 20, 1979						11:52P M				
3. SEX	4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female	White			February 28, 1880			99			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			United States			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown			Kent & Queen Anne's			Housewife											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Kent		Rock Hall		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Main Street									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
James			Elizabeth Copper			No			213-74-2859			Hospital Records, Chestertown, Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d))			4029			- Cerebral Hemorrhage											
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last			4029			DUE TO, OR AS A CONSEQUENCE OF (b) HSCU											
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension & CVA																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(d)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 20, 1979, to June 20, 1979, that (I) (we) last saw the deceased alive on June 20, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Patrick A. Molony M.D.</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony M.D.			22e. ADDRESS Chestertown, Maryland														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-24-79			23c. NAME OF CEMETERY OR CREMATORIAL We Wesley Chapel Cemetery Rock Hall, Kent Co. Md.			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
24. FUNERAL DIRECTOR <i>H. Helfenbein-Hubbard Funeral Home, Chester, Md.</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 27 1979			25b. REGISTRAR'S SIGNATURE <i>H. Helfenbein-Hubbard</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transfer permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 in marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	1	5	1	2	9
												REG. NO.					
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
						Johnson			June 12, 1979						6:12 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Negro			June 12, 1979			0			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown			Kent and Queen Anne's Hospital														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Queen Anne's			Centreville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			318 South Commerce Street					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
John Lawrence Johnson			Anna May Pritchett														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
NO			Newborn			Hospital Records, Chestertown, Maryland						21620					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>interuterine anoxia</u>																	
7605 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>abruptio placenta</u>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>trauma (accidental fall of mother)</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1979</u> to <u>June 12, 1979</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>John L. Morgan</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22c. DATE SIGNED <u>6/13/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
John L. Morgan, M.D.			Chestertown, Maryland 21620														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Disposal			23b. DATE 6-18-79			23c. NAME OF CEMETERY OR CREMATORIAL Hospital Incinerator			23d. LOCATION CITY OR TOWN Chestertown			COUNTY Kent		STATE Md.			
24. FUNERAL DIRECTOR NAME R.W. Morris Colmen									25a. DATE REC'D. BY REGISTRAR JUN 25 1979			25b. REGISTRAR'S SIGNATURE <u>Henry McAleney</u>					
Kent & Queen Anne Hospital-Chestertown, Md.																	

C. S. LEWIS

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1. DECEASED NAME (Type or print)	First WILBERT	Middle LEWIS	Last QUILLENN	2a. DATE OF DEATH Month June 15 1979 Doy Year 9:50 M	2b. HOUR 9:50 M	
3. SEX male	4. RACE white	5. DATE OF BIRTH July 2, 1898		6. AGE (in years last birthday) 80	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Kent	Md.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne Hosp. Civilian State Worker (Ret.)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civilian State Worker (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD Fairlee		
14. FATHER'S NAME Reverdy Quillen	First	Middle	Last	15. MOTHER'S MAIDEN NAME Berdie Morris	Middle	Last
16a. WAS DECEASED EVER Yes, no or unknown no	IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 212 38 0661	17. INFORMANT Carol Quillen	183 Kent St. Chestertown, Md	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 2 hr 496- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction 2 hr (c) Chronic lung disease years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 5-12 , 19 79 , to 6-15 , 19 79 , that (I) (we) last saw the deceased alive on 6-18 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Harry Paul Ross</i>	DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 6/16/1979		
22d. PHYSICIAN'S NAME (Type) Harry Paul Ross	M.D.		22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/18/79	23c. NAME OF CEMETERY OR CREMATORIUM Chesterfield Cemetery	23d. LOCATION (City or Town) Centreville, Md.	(County)	(State)	
24. FUNERAL DIRECTOR <i>Willis Wells</i>	ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR DATE JUN 21 1979		25b. REGISTRAR'S SIGNATURE <i>Harry McElroy</i>		

0 1 2 1 3 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										9	1	5	1	3	1
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
John Shepard Raynor Jr.							June 23, 1979						12:31 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		January 28, 1909			70			MONTHS	YEARS	MONTHS	YEARS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Pennsylvania		U.S.A.					Kent County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown		Kent And Queen Anne's Hospital		METAL LATHER			CONSTRUCTION								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland		Kent		Rock Hall			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Haven Road						
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
John		Shepard		Raynor Sr.			Irene		NMN		Hartman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT			17. ADDRESS		21620						
No		187-05-8958		Hospital Records			Chestertown, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line, or 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
410 - Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b)															
DUE TO, OR AS A CONSEQUENCE OF Cerebral Anoxia - (b) (c)															
DUE TO, OR AS A CONSEQUENCE OF ASCVD															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1979, to June 23, 1979, that (I) (we) lost saw the deceased alive on June 23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Patrick A. Molony</i>										DEGREE					
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22d. DATE SIGNED					
22e. ADDRESS Patrick A. Molony, M.D. Chestertown, Maryland 21620															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6-27-79		23c. NAME OF CEMETERY OR CREMATORIAL ST. PAULS CHURCH CEM.			23d. LOCATION CITY OR TOWN near Chestertown			COUNTY Kent		STATE Md.			
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Fun. Home		ADDRESS Chester, Md. 21679		25a. DATE REC'D. BY REGISTRAR JUN 27 1979			25b. REGISTRAR'S SIGNATURE <i>Patricia McCready</i>								
BP _____															
DHMH-16 20M (VRA 15, 4) 7/78															

1 5 1 2 1 8 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1 was retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	1 5 1 3 2								
CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)							3. DATE OF DEATH			MONTH	DAY	YEAR	4. HOUR			
			HENRY CLAY SMITH							June			17, 1979			10 30 AM			
5. SEX			6. RACE			7. DATE OF BIRTH				8. AGE (IN YEARS LAST BIRTHDAY)			9. IF UNDER 1 YEAR		10. IF UNDER 24 HRS				
Male			White			Month June Day 1 Year 1896				83			YRS.		MONTHS DAYS HOURS MIN				
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			12. CITIZEN OF WHAT COUNTRY?			13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			15. KIND OF BUSINESS OR INDUSTRY						
Md.			U.S.A.			Home				Ret. Farmer			Farming						
16. CITY OR TOWN OF DEATH			17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				19. STREET ADDRESS			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Millington			Md. Kent			Millington				Ida L. Lamdin			Sudden						
21. FATHER'S NAME			22. MOTHER'S MAIDEN NAME			23. SOCIAL SECURITY NO.				24. INFORMANT			25. ADDRESS						
Samuel			Ida			220-26-2238				Elizabeth B. Smith, Millington, Md.			21651						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.										16b. SOCIAL SECURITY NO. 220-26-2238									
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>										18. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac insufficiency</u>									
2859 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anemia</u>										19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
20. MEDICAL CERTIFICATION			21. DATE OF OPERATION			22. CONDITION FOR WHICH OPERATION WAS PERFORMED				23. AUTOPSY?			24. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
										YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			26. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			27. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
29. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			30. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			31. LOCATION STREET				CITY OR TOWN			COUNTY		STATE				
32. I certify that (I) (this hospital) attended the deceased from <u>June 9</u> 1979, to <u>June 17</u> 1979, that (I) (we) last saw the deceased alive on <u>June 7</u> 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										33. SIGNATURE <u>Geza Koralewski</u> -									
34. ATTENDING PHYSICIAN										35. DEGREE		36. DATE SIGNED							
37. PHYSICIAN'S NAME (TYPE OR PRINT)										MD		6-17-79							
38. BURIAL, CREMATION, REMOVAL (SPECIFY)										39. NAME OF CEMETERY OR CREMATORIAL ADDRESS		40. LOCATION CITY OR TOWN				41. COUNTY		42. STATE	
Burial										6/20/79		Millington Cemetery				Millington		Kent	
43. FUNERAL DIRECTOR NAME										44. ADDRESS		45. DATE REC'D. BY REGISTRAR				46. REGISTRAR'S SIGNATURE			
Howard E. Fellows, Millington, Md. 21651												JUN 6 1979				Linton McBrady			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

MEDICAL CERTIFICATION

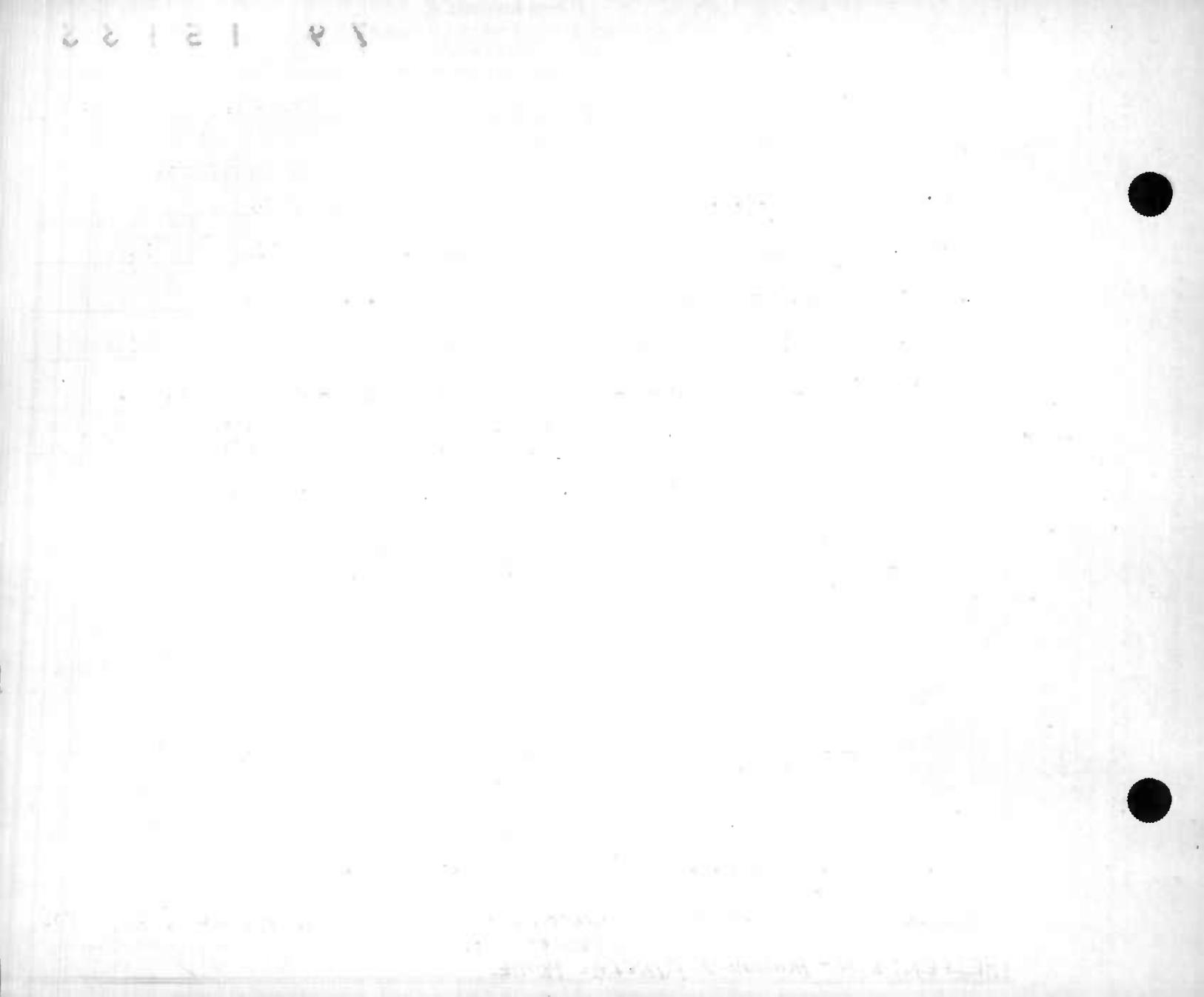
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 5 1 3 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Bessie			May		Tolson	June 26, 1979				10:55 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		white		MONTH April 8, 1880 DAY		99		MONTHS DAYS		HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		U.S.A.				Kent County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		Kent & Queen Anne's Hospital, Inc.		housewife		home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Queen Anne		Chestertown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 472			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. MIDDLE		LAST		
		Caleb	?	Davis	FIRST	Rebecca	?		Robinson		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		-		220-46-3123		Hospital records - Chestertown, Md.					
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> year											
4292 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Chronic congestive failure</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<i>① Bronchitis ② Diabetes mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) <input type="checkbox"/> (we) <input type="checkbox"/> attended the deceased from <u>June 24, 1979</u> to <u>June 26, 1979</u> , that (I) <input type="checkbox"/> (we) <input type="checkbox"/> last saw the deceased alive on <u>June, 26, 1979</u> , and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <i>Harry P. Ross, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6-29-79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Harry P. Ross, M.D.		22e. ADDRESS Chestertown, Md. 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-29-79		23c. NAME OF CEMETERY OR CREMATORIAL STEVENSVILLE CEM.		23d. LOCATION CITY OR TOWN STEVENSVILLE		COUNTY Q.D.		STATE MD	
24. FUNERAL DIRECTOR NAME HELFENBEIN - HUBBARD FUNERAL HOME		ADDRESS CHESTER MD		25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTRAR'S SIGNATURE <i>Henry J. Murphy</i>					



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

15134

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR P 3:30				
EUGENE SPENCER WESSEL								<input checked="" type="checkbox"/>									
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR P 4:45				
male	white	4/20/1927	52 yrs.	MONTHS	DAYS	HOURS	MIN	<input checked="" type="checkbox"/>									
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.					
Maryland		USA															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Mr. Chestertown		Route # 20		Clerk		Acme Stores											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Kent		Chestertown				RFD Pomona									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Spencer Wessel						Katherine Bland											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT Mirian Wessel		17. ADDRESS Chestertown, Md.											
no		218 20 6583															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 8120 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		DUE TO, OR AS A CONSEQUENCE OF															
{ (b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
Driver of car involved in head on collision																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 3:30 P.M. 6-24 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Route 20		21f. LOCATION STREET 3 miles from Chestertown Kent Maryland		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Robert W. Farr</u>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED		6/24/79									
EXAMINER'S NAME (TYPE OR PRINT)		Robert W. Farr		Chester Cemetery		Chestertown		Md.		21620							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 6/28/1979		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME Willie Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE <u>John McCreedy</u>											
BP																	
DHMH-17 (VR A15 ME (5))																	
15M 7/76																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	15	135	
												REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			P			
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			June 21, 1979			4:15 M						
Clara Frances Wheeler															
3 SEX Female			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR May 4, 1918			6. AGE (IN YEARS LAST BIRTHDAY) 61			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County			MD.			
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Production Line			12b. KIND OF BUSINESS OR INDUSTRY Food						
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P.O. Box 105			
14. FATHER'S NAME FIRST MIDDLE LAST Melvin James Crew			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mae Lloyd												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-09-5604			17. INFORMANT Hospital Records, Chestertown, Maryland			ADDRESS 21620						
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of lung with metastases															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from June 6, 1979, to June 21, 1979, that (I) (we) last saw the deceased alive on June 21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Molony												DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony, M.D.			22e. ADDRESS Chestertown, Maryland 21620												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-23-79			23c. NAME OF CEMETERY OR CREMATORIAL CRUMPTON CEMETERY			23d. LOCATION CITY OR TOWN CRUMPTON			COUNTY O.A. Co.	STATE MD.		
24. FUNERAL DIRECTOR NAME HELFENBEIN-HUBBARD FUNERAL HOME			ADDRESS CHESTER MD			25a. DATE REC'D. BY REGISTRAR JUN 27 1979			25b. REGISTRAR'S SIGNATURE Lester McBrady						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	1	5	1	3	6			
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	20. DATE OF DEATH				MONTH	DAY	YEAR	26. HOUR									
William	Bernard	Willson		June				19	1979		8:10 P.M.									
SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS										
Male	White	MONTH	DAY	YEAR	63			MONTHS	DAYS	HOURS	MIN.									
BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland	U.S.A.						Kent County													
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY									
Chestertown	Kent And Queen Anne's Hospital					Truck Driver					---									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			MD.											
Maryland	Kent	Rock Hall				P.O. Box# 119														
14. FATHER'S NAME	FIRST	MIDDLE	LAST	DEC.	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST	DEC.										
Leonard	Augustine	Willson			Fist Gladys			Elizabeth		Boyer										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS													
Yes	Army WWII			220-03-7959			Hospital Records			Chestertown, Maryland										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (d)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.												ACUTE MYOCARDIAL INFARCTION 2 DAYS								
DUE TO, OR AS A CONSEQUENCE OF (b)																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
DIABETES MELLITUS																				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE										
22a. I certify that (I) (was hospital) attended the deceased from June 18, 19 79, to June 19, 19 79, that (I) (was) death occurred on the date and hour and from the causes stated saw the deceased alive on June 19, 19 79, and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (was) view the body after death.												22c. DATE SIGNED 6-20-79								
22b. SIGNATURE Harry P. Ross, M.D.												DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS Chestertown, Maryland 21620								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE										
Burial	6-22-79	Wesley Chapel Cem.			Rock Hall			Kent Co.		Md.										
24. FUNERAL DIRECTOR NAME	ADDRESS					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Helfenbein-Hubbard	Funeral Home, Chester Md.					JUN 27 1979			Helfenbein-Hubbard											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 9 1 5 1 3 7											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Norris			Eugene			Wilson						May 26, 1979											
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR March 31, 1891			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS								
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			10. CITY OR TOWN OF DEATH Worton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS At Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor			12b. KIND OF BUSINESS OR INDUSTRY Various		
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Worton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS R.F.D.#											
14. FATHER'S NAME FIRST John			MIDDLE			LAST Wilson			15. MOTHER'S MAIDEN NAME FIRST Susie			MIDDLE			LAST White								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO 214-28-8079			16c. INFORMANT Mrs. Mary Brooks Worton, Md.			17. ADDRESS R.F.D.#														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks											
(b). <i>Cerebrovascular Accident</i> (c). <i>Atherosclerotic Cardiovascular Disease, years</i>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN 5/19/79																	
22a. I certify that (I) (this hospital) attended the deceased from <i>April 19, 1979</i> to <i>May 26, 1979</i> , that (I) (we) lost saw the deceased alive on <i>May 26, 1979</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>Charles P. Adamo M.D.</i>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN M.D.			22e. MEDICAL DIRECTOR <input type="checkbox"/>			22f. STAFF PHYSICIAN <input type="checkbox"/>			22g. DATE SIGNED 5.29.79								
22g. PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Adamo M.D.			22h. ADDRESS Chestertown, Maryland 21620																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 30, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Union United Cem.			23d. LOCATION CITY OR TOWN R.F.D. Worton Kent Md.			23e. COUNTY STATE											
24. FUNERAL DIRECTOR <i>Tenith Wiley</i>			25a. ADDRESS Chestertown, Md.			25b. DATE REC'D. BY REGISTRAR JUN 19 1979			25c. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												9	1	5	1	3	8						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Dorra			Ross			Young						June 5, 1979						10:15 P.M.					
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR March 10, 1903			6. AGE (IN YEARS LAST BIRTHDAY) 76			IF UNDER 1 YEAR MONTHS			# UNDERR 24 HRS HOURS MIN.								
7a. BIRTHPLACE <u>Arkansas</u>			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent County			10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dental Assist.			12b. KIND OF BUSINESS OR INDUSTRY Dentistry		
13a. STATE W. Va.			13b. COUNTY Morgan			13c. CITY OR TOWN Berkeley Springs			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Route 3											
14. FATHER'S NAME FIRST William			MIDDLE			LAST Ross			15. MOTHER'S MAIDEN NAME FIRST Victoria			16. ADDRESS 21620											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 421-26-8667			17. INFORMANT Hospital Records			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory Failure																							
4380 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) COPD			DUE TO, OR AS A CONSEQUENCE OF (c) CHF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (I) (this hospital) attended the deceased from May 28 , 1979, to June 5 , 1979, that (I) (we) last saw the deceased alive on June 5 , 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																							
22b. SIGNATURE <i>K. K. Wun, M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED June 5, 1979														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kin K. Wun, M.D.			22e. ADDRESS Chestertown, Maryland 21620																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/7/79			23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery			23d. LOCATION CITY OR TOWN Morgan Co., W. Va.			23e. COUNTY STATE											
24. FUNERAL DIRECTOR NAME W. W. Helsley, Berkeley Springs, W. Va.			25a. ADDRESS W. W. Helsley, Berkeley Springs, W. Va.			25b. DATE REC'D. BY REGISTRAR JUN 12 1979			25c. REGISTRAR'S SIGNATURE <i>W. W. Helsley</i>														

